Association of Critical Care Transport (ACCT)

AFFILIATE MEMBERSHIP APPLICATION

Please submit your completed and signed membership application to Fax # (816) 858-6177, or mail to Association of Critical Care Transport, PO Box 170, Platte City, MO 64079 or email to, mcoons@medserv.us. For any questions regarding the membership application, please contact Melissa Coons at (816) 858-6175, or mcoons@medserv.us , or ACCT Executive Director Roxanne Peek at rpeek@acctforpatients.org.

Membership Information

Name of Organization: _____

Street/Mailing Address: _____

City, State, Zip: _____

Primary Contact: _____ Title: _____

Email: _____ Website: _____

Work Phone #: _____ Cell Phone #: _____

Program Information

Affiliate Membership is $660 per year. Please see the ACCT Membership Benefits and Dues information at www.acctforpatients.org for detailed information.

Participation in ACCT

Areas of Interest for Specific Involvement for Primary Contact:

- ☐ Finance and Development Committee
- ☐ Communications Committee
- ☐ Standards/Quality Metrics Committee
- ☐ Education Committee
- ☐ Governance Committee
- ☐ Policy Committee

Areas of Interest for Specific Involvement for Other Individuals in Your Organization:

Please provide contact information and interest areas for other individuals in your organization who will be participating in ACCT:

Areas of Interest:

- ☐ Finance and Development Committee
- ☐ Communications Committee
- ☐ Standards/Quality Metrics Committee
- ☐ Education Committee
- ☐ Governance Committee
- ☐ Policy Committee

Name/Title: _____ Work Phone: _____

Email: _____ Cell: _____

Areas of Interest:

- ☐ Finance and Development Committee
- ☐ Communications Committee
- ☐ Standards/Quality Metrics Committee
- ☐ Education Committee
- ☐ Governance Committee
- ☐ Policy Committee

Name/Title:_____ Work Phone: _____

Email:_____ Cell: _____

Dues Payment Information

Payment Methods

Payment options for Associate Member annual dues (please check one).

- ☐ Credit Card (a processing fee may apply)
- ☐ Payment Enclosed; Check #_____
  (Payable to Association of Critical Care Transport, PO Box 170, Platte City, MO 64079)
- ☐ Request for Invoice

Credit Card payment

☐ Visa ☐ MasterCard
☐ American Express ☐ Discover

Card #: _____

Expiration Date (month/year): _____

Authorizing Signature:

_____

Credit Card Billing Address (if different from above):

Name on card: _____

Address:_____

City:_____State:_____Zip:_____

Country:_____Phone:_____

Email:_____

Invoice: Name and address where invoice should be sent if different than the primary contact listed on page one.

Name: _____

Street/Mailing Address: _____

City, State, Zip:_____Phone: _

_____ Email: _____

General Support of ACCT Vision, Mission, Values and Platform

Your signature at the end of the application form is an affirmation of your general agreement to support the Vision, Mission, Values and Platform (outlined on the website www.acctforpatients.org) of ACCT.

I,_____ (print name) generally support the Vision, Mission, Values and Platform as outlined above, of the Association of Critical Care Transport (ACCT).

_____

Signature **Date**